Indiana Health Coverage Programs

Standard Companion Guide Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

Health Care Claim Status Request and Response (276/277)

Companion Guide Version Number: 3.3
Revision Date: July 2019

This template is Copyright © 2010 by The Workgroup for Electronic Data Interchange (WEDI) and the Data Interchange Standards Association (DISA), on behalf of the Accredited Standards Committee (ASC) X12. All rights reserved. It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holder. This document is provided "as is" without any express or implied warranty. Note that the copyright on the underlying ASC X12 Standards is held by DISA on behalf of ASC X12.

Companion Guide © copyright 2012 by DXC Technology

Preface

The Health Insurance Portability and Accountability Act (HIPAA) adopted standard transaction sets for Electronic Data Interchange (EDI) of health care data. Covered entities must adhere to the content and format requirements as defined in the ASC X12N Implementation Guides.

The Indiana Health Coverage Programs (IHCP) has developed this document to serve as a companion document to provide guidance and clarification as it applies to the IHCP. It is not intended to modify, contradict or reinterpret the rules established by the ASC X12N Implementation Guides.

Table of Contents

1 TI Introduction ... 5

1.1 Background ... 5

1.1.1 Overview of HIPAA Legislation ... 5

1.1.2 Compliance according to HIPAA ... 5

1.1.3 Compliance according to ASC X12 ... 5

1.2 Intended Use ... 6

2 Included ASC X12 Implementation Guides ... 7

3 Instruction Tables ... 8

4 TI Additional Information ... 12

4.1 Business Scenarios ... 12

4.2 Payer Specific Business Rules and Limitations ... 12

4.2.1 Claim Status Request (276) Search Options ... 12

4.2.2 Claim Status Request (276) Processing Guidelines ... 12

4.2.3 Claim Status Request (276) Interchange Control Header ... 13

4.2.4 Claim Status Request (276) Functional Group Header ... 13

4.2.5 Claim Status Response (277) Processing Guidelines ... 14

4.2.6 Claim Status Response (277) Interchange Control Header ... 14

4.2.7 Claim Status Response (277) Functional Group Header ... 14

4.3 Frequently Asked Questions ... 14

4.4 Other Resources ... 14

5 TI Change Summary ... 16

Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

The associated ASC X12 TR3 is available at http://store.x12.org/store

Unique ID	Name
005010X212	Health Care Claim Status Request and Response (276/277)

3 Instruction Tables

These tables contain rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

V5010X212 Health Care Claim Status Request (276)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
41	2100A	NM1	Payer Name			
41	2100A	NM103	Name Last or Organization Name			IHCP uses "HP"
42	2100A	NM108	Identification Code Qualifier	PI		IHCP only recognizes value PI
42	2100A	NM109	Identification Code			IHCP uses "IHCP"
45	2100B	NM1	Information Receiver Name			
46	2100B	NM109	Identification Code			Use the submitter ID assigned by the IHCP
49	2100C	NM1	Provider Name			IHCP expects this segment to contain billing provider information as sent on the original claim
51	2100C	NM108	Identification Code Qualifier			IHCP expects SV to be used by atypical providers
52	2000D	HL	Subscriber Level			The IHCP patient is always the subscriber
56	2100D	NM1	Subscriber Name			IHCP expects this segment to contain the IHCP member name and ID as sent on the original claim.
57	2100D	NM108	Identification Code Qualifier	MI		MI is the only value recognized by the IHCP
57	2100D	NM109	Identification Code		12	The IHCP subscriber identification number is 12 digits
59	2200D	REF	Payer Claim Control Number			
	2200D	REF02	Reference			The IHCP ICN number is 13 digits

59			Identification			
69	2210D	SVC	Service Line Information			The IHCP expects this segment, if sent, to contain identical values as submitted on the original claim
69	2210D	SVC01-01	Product/Service ID Qualifier	AD HC N4 NU		IHCP supports the following Service ID Qualifiers: AD – American Dental Association Codes HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes N4 – National Drug Code (NDC) in 5-4-2 Format NU – National Uniform Billing Committee (NUBC) UB04 Codes This code is the NUBC Revenue Code
73	2210D	REF	Service Line Item Identification			The IHCP expects this segment, if sent, to contain identical values as submitted on the original claim
73	2210D	REF02	Reference Identification			The IHCP supports line item control numbers of up to 30 characters
75	2000E	HL	Dependent Level			The IHCP patient is always the subscriber

V5010X212 Health Care Claim Status Response (277)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
111	2100A	NM1	Payer Name			
111	2100A	NM103	Name Last or Organization Name			IHCP uses "HP"
112	2100A	NM109	Identification Code			IHCP uses "752548221"
118	2100B	NM1	Information Receiver Name			IHCP returns the information receiver name as stored in Indiana Core MMIS
126	2100C	NM1	Provider Name			IHCP returns the provider name as stored in Indiana Core MMIS
128	2100C	NM108	Identification Code Qualifier			IHCP uses SV for atypical providers
133	2000D	HL	Subscriber Level			The IHCP patient is always the subscriber
135	2100D	NM1	Subscriber Name			IHCP returns the subscriber name as stored in Indiana Core MMIS
	2100D	NM109	Identification			The IHCP subscriber identification number

136			Code		12	is 12 digits
138	2200D	STC	Claim Level Status Information			
138	2200D	STC01-01	Industry Code	A4 EO F1 F2 P1 P2 P3		IHCP uses the following category codes based on the listed definitions: A4 – Primary search data is valid, such as the provider number or member ID, however, there are no claims matching the criteria. E0 – Primary search data is invalid, such as the provider identifier, member ID, and so forth. F1 – The claim either has paid or will pay in the next financial payment cycle. F2 – The claim denied. P1 – The claim is in the adjudication system P2 – The claim is currently in suspended status pending the IHCP review of claim. P3 – This claim is currently in a suspended status awaiting the return of a claim correction form (CCF). **Claim Status Category Code E0 is used when certain data submitted on the 276 cannot be validated; therefore, no search can be performed: * The provider identifier submitted in NM109 (2100A loop) not found on Indiana *Core*MMIS database. * The IHCP member ID submitted in NM109 (2100D loop) not found on Indiana *Core*MMIS database.
138	2200D	STC01-02	Industry Code	1 2 3 4		IHCP uses the following status codes based on the listed definitions: 1. Service lines returned with Claim Status Category Codes F1 (Paid) and F2 (Denied) contain a claim status code value of 1 – For more detailed information, see remittance advice or 101-Claim was processed as adjustment to previous claim. 2. Claims with a Claim Status Category Code of P2 (Pending/In Review) and P3 (Pending/Requested Information) receive a claim status code from external code set 508 providing additional explanation. 3. Paid claims that are in the process of being voided or replaced with a Claim Status Category Code of P1(Pending/In Process) receive a claim status code value of 1 - For more detailed information, see

						remittance advice. 4. Suspended and CCF claims that have a Claim Status Category Code of P1 will receive a claim status code from external code set 508 providing additional explanation or it will receive a claim status code of 20 – Accepted for processing.
139	2200D	STC01-03	Entity Identifier Code	82 85 QC DN P3 QH		IHCP uses the following codes: 82 – Rendering Provider 85 – Billing Provider QC – Insured or Subscriber DN – Referring Provider P3 – Primary Care Provider QH – Physician
145	2200D	STC04	Monetary Amount			IHCP returns the total charges submitted on the original claim and matches the amount submitted on the 276 request
145	2200D	STC06	Date			IHCP returns the date the claim processed if the claim has not been through the financial cycle
149	2200D	REF	Payer Claim Control Number			
149	2200D	REF02	Reference Identification			The IHCP ICN number is 13 digits
173	2000E	HL	Dependent Level			The IHCP patient is always the subscriber

4 TI Additional Information

This section must contain one or more of the following situational sections, if applicable.

4.1 Business Scenarios

Not applicable.

4.2 Payer Specific Business Rules and Limitations

All references to the IHCP in this Companion Guide refer to Indiana Health Coverage Programs.

All references to the IHCP provider number in this Companion Guide refer to the Indiana Health Coverage Program Legacy Provider number (LPI).

4.2.1 Claim Status Request (276) Search Options

4.2.1.1 The request contains minimum required data elements used by the IHCP for search criteria.

These data elements include:

- Provider identifier
- IHCP member ID
- Dates of service
- Total claim charge amount

4.2.1.2 Requestors with additional information can also submit data such as ICN, medical record number and institutional type of bill to assist in the search.

4.2.1.3 Those interested in obtaining service or detail line status information can also inquire at that level.

4.2.1.4 All data submitted is used for search purposes, therefore the slightest differences between submitted data and data on the original claim results in no match.

4.2.2 Claim Status Request (276) Processing Guidelines

4.2.2.1 The 999 Acknowledgement acknowledges the receipt of the batch transaction and reports the acceptance or rejection of a functional group, transaction set or segment.

4.2.2.2 Providers should wait at least one day after submitting a claim before initiating a 276 request.

4.2.2.3 Claims submitted by the provider to a managed care organization (MCO), which are in turn submitted to the IHCP, are known as encounter claims. These encounter claims are not available for inquiry.

4.2.2.4 Dependent loops (2000E, 2100E, 2200E and 2210E) are not used because the IHCP members, or subscribers, are always the same as the patient. Therefore, these loops should not be submitted.

4.2.2.5 All monetary amounts have explicit decimals. The decimal point always appears in the character stream if the decimal point is at any place other

than the right end. If the value is an integer, (decimal point at the right end), the decimal point should be omitted.

4.2.2.6 If utilizing a decimal point in a code field, it must be in the correct position per the code set guidelines, otherwise it may be returned as an error.

4.2.2.7 Data elements with lengths greater than IHCP definitions are truncated, such as the IHCP member ID is 12 bytes

4.2.2.8 Only one claim status request per transaction is allowed when submitting a 276 transaction in interactive mode.

4.2.2.9 Service level requests are not accepted on interactive 276 transactions. An interactive 276 transaction request containing service line data is rejected and a response of 991 is returned.

4.2.3 Claim Status Request (276) Interchange Control Header

4.2.3.1 Interchange Sender ID (ISA06) – This is the sender ID assigned by the IHCP.

4.2.3.2 Interchange Receiver ID (ISA08) – Required value is IHCP.

4.2.4 Claim Status Request (276) Functional Group Header

4.2.4.1 Application Sender Code (GS02) – This is the sender ID assigned by the IHCP.

4.2.4.2 Application Receiver’s Code (GS03) – Required value is IHCP.

4.2.4.3 IHCP expects only one iteration of the functional group control segment (GS/GE).

4.2.5 Claim Status Response (277) Processing Guidelines

4.2.5.1 Certain required provider/subscriber data elements that are submitted on a 276 request may or may not exactly match the values returned on the 277 response. In these cases, the IHCP returns the values currently contained in Indiana Core MMIS records. These include the following data elements:

- Information Receiver Name (2100B Loop, NM103) will contain the Trading Partner ID
- Provider Name (2100C Loop, NM103) {includes the NPI if a healthcare provider or the LPI/provider location if an atypical provider}
- Subscriber Demographic Information (2000D Loop, DMG02, and DMG03)
- Subscriber Name (2100D Loop, NM103-5)

4.2.5.2 Requests containing an invalid provider identifier or member ID cannot be returned from the database. The data elements are returned exactly as received on the 276 request.

4.2.5.3 Claims in suspended or Claims Correction Form status, are returned with HIPAA error codes in the 277 response transaction.

4.2.5.4 The National Provider Identifier (NPI) will be returned on the 277 transaction if the NPI has been reported to the IHCP.

4.2.5.5 A claim status request submitted with claim level information only receives a claim level status response. Likewise, a claim status request submitted for a specific service or detail only generates a response based on the search criteria established for the single service or detail level even if there are more details on the claim. If multiple service or detail lines meet the search criteria, each matching detail is returned.

4.2.5.6 If multiple claims meet the claim level search criteria, the IHCP only returns responses for the 12 most current claims on file.

4.2.6 Claim Status Response (277) Interchange Control Header

4.2.6.1 Interchange Sender ID (ISA06) – Value is IHCP

4.2.6.2 Interchange Receiver ID (ISA08) – This is the sender ID assigned by the IHCP.

4.2.7 Claim Status Response (277) Functional Group Header

4.2.7.1 Application Sender Code (GS02) – Value is IHCP

4.2.7.2 Application Receiver's Code (GS03) – This is the sender ID assigned by the IHCP.

4.3 Frequently Asked Questions

This section contains a compilation of questions and answers.

4.4 Other Resources

This section lists other references or resources.

DXC EDI Solutions
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204
INXIXTradingPartner@dxc.com

Indiana Medicaid for Providers website
https://www.in.gov/medicaid/providers/index.html

Electronic Data Interchange (EDI) Solutions
https://www.in.gov/medicaid/providers/697.htm

IHCP Provider Reference Materials
https://www.in.gov/medicaid/providers/469.htm

News, Bulletins and Banner pages
https://www.in.gov/medicaid/providers/737.htm

5 TI Change Summary

This section describes the differences between the current Companion Guide and previous guide(s).

Version	CO	CO Name	Revision Date	Revision Status	Revision Page Numbers/Change/Update Details	Completed by
2.0	2178		Dec 2012	New	CAQH CORE format	Systems
3.0			Nov 2016	Implemented	Indiana Core MMIS Implementation	Systems
3.1			Jan 2017	Implemented	Pg. 18 – Added bullet 4.2.4.3 – IHCP expects only one iteration of the functional group control segment.	Systems
3.2			April 2017	Implemented	Updated throughout document Hewlett Packard Enterprise (HPE) to DXC Technology	Systems
3.3			July 2019	Implemented	Pg. 14 and 15. Updated links to Indiana Medicaid for Providers web site	Systems